CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE MEDIAL INFORMATION AND TO PAY BENEFITS TO ALPINE CARDIOLOGY, PLLC

By signing below, I (or my authorized representative on my behalf) authorize Alpine Cardiology physicians and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual health care providers to explain to me the reasons for any particular examination, test or procedure, the available treatment options as well as alternative courses of treatment.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

I hereby authorize Alpine Cardiology and its employees and agents to release my medical records, documenting my examination and treatment, including AIDS related testing, psychiatric or substance abuse information, upon valid request.

I hereby assign payment directly to Alpine Cardiology for any medical/surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I agree to be financially responsible to Alpine Cardiology for all charges in the event that I have no insurance or my insurance is rejected, and for any balance or fee not covered by by insurance and/or determined to be my responsibility. I understand and acknowledge that if Alpine Cardiology through our billing service (Mid Michigan Medical Billing Associates) files my insurance claim, I will remain responsible for the account, and I will be expected to pay any amount due if my insurance does not pay the claim within 45 days. I acknowledge that any amounts quoted as my "out of pocket costs" are only an estimate and that the exact determination of my financial responsibility will be made after my insurance company processes the claim. Payment is expected at the time of service. Methods of payment accepted include check and cash.

I further agree to pay all costs of collection, including reasonable attorney's fees, at the legal rate of interest on the account until paid in full, and I agree to waive all rights of exemption under the Constitution and the laws of the State of Michigan.

I hereby request and authorize all doctors, nurses, technicians or affiliated medical personnel, hospitals, and health care facilities to furnish all records and reports, including x-rays, photostatic copies, and abstracts or excerpts of all records and any other information requested relating to any hospitalizations, examinations, treatments, tests or opinions concerning any condition for which I am presently being treated, including AIDS related testing, psychiatric or substance abuse information. A copy of this authorization shall be as valid as the original of this document.

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PLEASE PRINT PATIENT'S FULL NAME **PATIENT'S SIGNATURE**

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DATE **WITNESS SIGNATURE**